WITHIN CORPORATE LIMITS

Duplicate Edition

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

CERTIFICATE OF DEATH

09600

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No. School St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ronald Lewis Almond

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 5, 1944

8. AGE:

Years	Months	Days	If less than one day
0	11	25	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER — 12. Name Calvin Lewis Almond

13. Birthplace Maryland

MOTHER — 14. Maiden name Barbara Jean Frazier

15. Birthplace Maryland

18. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2 1945 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Nov 1, 45 (Date rec'd by registrar) Walter L. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1945, at 8:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15 1945, to 10-30 1945 and that I last saw h.. alive on 10-30 1945

Immediate cause of death	DURATION
Rickets	6 Mos
Secondary Anemia	4 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Almond M. D. or other

Address 126 Union St Cumberland Md Date signed 10/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-d)

CERTIFICATE OF DEATH

09601

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: 213 Seeley St.

How long in hospital or institution? 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Seeley St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Aspinall

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Aspinall

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1855

8. AGE: Years: 90 | Months: 8 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Ocean Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Chas. Kaufer

13. Birthplace: Germany

MOTHER

14. Maiden name: Elizabeth N. Browning

15. Birthplace: Germany

16. Informant: Miss Lilly Aspinall

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 20 '45 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg Md

18. Funeral director: Louis Stein & Sons

Address: Cumberland

19. Oct. 19 1945 (Date rec'd by registrar) Victor K. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1945, to Oct 17 1945

and that I last saw h[illegible] alive on ..... 19.....

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Duration 3 months	
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. W. Markwood M.D. M. D. or other

Address: 9 Greene St. Date signed: 10-18-45

WITHIN CORPORATE LIMITS SON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

09603

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 39 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 517 WILLIAMS ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MR MELVIN BARKMAN

3. (b) Social Security Number: 214-05-3471

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARY D. HINISH
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): JUNE 5 1903

8. AGE: Years	Months	Days	If less than one day
42	4	24	....hrs. ....min.

9. Birthplace: PA (Town, county, and state)
10. Usual occupation: KELLY SPRINGFIELD TIRE
11. Industry or business
FATHER 12. Name: EMMANUEL BARKMAN
13. Birthplace: PA
MOTHER 14. Maiden name: FLORENCE SOWERS
15. Birthplace: PA.
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1945 (month) (day) (year)
Cemetery or crematory: HillCrest Burial Park
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. Oct. 31, 1945 (Date rec'd by registrar) Winter R. Tsanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 29 1945, at 6:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1945, to Oct. 29 1945, and that I last saw h.. alive on Oct. 28 1945

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Endocarditis	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Chronic Hypertrophied Myocarditis - Endocarditis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. L. Pearson M.D. M. D. or other
Address: 126 Harrison Cumberland Md. Date signed: 10-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

USA 09602

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred: Allegany Co Sanitarium

How long in hospital or institution? 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 620 Elm St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William F Barley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Agnes Lehman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Carpenter.

11. Industry or business Retired

FATHER 12. Name Thomas J Barley

13. Birthplace Md

MOTHER 14. Maiden name Catherine Weber

15. Birthplace Md.

16. Informant Frank Barley

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 45 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct 29 1945 (Date rec'd by registrar) Winter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1945 at 7A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 27 1945 to Oct 28 1945 and that I last saw him alive on Oct 27 1945

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 10-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09604

Reg. Dist. No. 4

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 yrs.
Hospital, institution, or street address where death occurred:
204 Pear St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 Pear St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ANNA MAE BARNARD.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED.

6.(b) Name of husband or wife R. MARSHALL BARNARD. 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	3	... hrs. ... min.

9. Birthplace Cumberland. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Joseph C. Taylor
13. Birthplace Md.

MOTHER
14. Maiden name KATHORINE FRIETHOFF.
15. Birthplace Md.

16. Informant R. Marshall Barnard.
Address 204 Pear St. Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 10/16/45 (month) (day) (year)
Cemetery or crematory St. Peter & Paul Cem.
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland Md.

19. Oct. 15, 1945 Winter R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1945, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 13. 1945, to Oct. 13, 1945
and that I last saw h... alive on Oct. 13, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wray R. Turner M. D. or other
Address Cumberland Date signed 10-13-45

WITHIN CORPORATE LIMITS

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

09605

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HSOPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 707 VIRGINIA AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME BABY GIRL BARNHART

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 17, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hrs. min.

9. Birthplace CUMBERLAND, MD. ALLEGANY
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name
FATHER 13. Birthplace

MOTHER 14. Maiden name PATRICIA BARNHART
MOTHER 15. Birthplace MARYLAND

16. Informant MEMORIAL HSOPITAL
Address CUMBERLAND, MD.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1945 (month) (day) (year)

Cemetery or crematory MEMORIAL HOSPITAL
Location Cumberland, Md.

18. Funeral director Same
Address

19. Oct 18, 1945 (Date rec'd by registrar) Walter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 18, 1945, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17, 1945, to Oct 18, 1945
and that I last saw him alive on Oct 18, 1945

	DURATION
Immediate cause of death: Premature birth	
Due to: (6 months gestation)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other
Address Cumberland Md. Date signed 10-18-45

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

09606

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month 29 Days

Hospital, Institution, or street address where death occurred:

Bowmans Addition

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bowmans Addn., Rt. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Donna Jean Beall

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25 1945

8. AGE: Years	Months	Days	If less than one day
	1	29	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Vernon Bell

13. Birthplace: Cumberland, Md

MOTHER

14. Maiden name: Nellie Smith

15. Birthplace: Crowder, Virginia

16. Informant: Vernon Bell

Address: Bowmans Addition, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/26/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 26 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24th., 1945 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Malnutrition; Inanitition	2 mos.
Due to (One of twins)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer H. Bowen, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 10/25/45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....

City or Town .....

If outside city or town limits, write SURAL and give nearest town)

Hospital, institution, or street address where death occurred:

Was [illegible] a hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) Full name.

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife .....

7. Date of birth:

Year | Month | Day | If less than one day

7.(a) If 1 day, give age in ..... hrs. ..... min.

8. Birthplace

(Town, county, and state)

9. Usual occupation .....

10. Industry or business .....

11. Name .....

12. Birthplace .....

13. Maiden name .....

14. Birthplace .....

15. Name .....

16. Address .....

17. Date buried .....

(Month, day, year)

Cemetery or crematory .....

(Burial, cremation, or removal, Which?)

Undertaker .....

Address .....

18. Funeral director .....

Address .....

19. Date signed .....

(Month, day, year)

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... 19 .....

21. I HEREBY CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.... alive on ..... 19.....

To confirm above and death .....

Immediate cause .....

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operation .....

Autopsy? .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or Town) (County) (State)

Injured at home, farm, industry, public place (which?) .....

Nature of injury ..... Injured at work?

23. SIGNATURE .....

M. D. or other

Address .....

DR. HAWKINS

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

02607

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: ALLEGANY
City or town: ~~MIDLAND, MD.~~ Gilmore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth
MRS MARGARET ^BEEMAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Widowed

6.(b) Name of husband or wife: THOMAS BEEMAN
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): MARCH 28, 1878

8. AGE: Years	Months	Days	If less than one day
67	6	6	..... hrs. ..... min.

9. Birthplace: Near Boonsboro, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business: Own Home

FATHER
12. Name: JACOB WALBERT
13. Birthplace: GERMANY

MOTHER
14. Maiden name: MARGARET DICE
15. Birthplace: GERMANY

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cem
Location: Boonsboro, Md.
18. Funeral director: M. Eichhorn
Address: Lanaman and

19. Oct 4 1946 (Date rec'd by registrar) W. T. R. Entz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 4, 1945, at 5:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13, 1945, to October 4, 1945
and that I last saw her alive on October 3, 1945

Immediate cause of death	DURATION
(a) Carcinoma	
Due to (b) Carcinoma of Stomach, Primary	
Due to (c) Metastatic	
Other conditions contributing but not related to (a) (Include pregnancy within 3 months of death)	

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. H. Hawkins, M. D. or other
Address: ..... Date signed .....

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

09608

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town WESTERNPORT, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BLANCHE BRUMAGE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: William Brumage 6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): March 3, 1882

8. AGE: Years: 63 Months: 7 Days: 24 If less than one day: hrs. min.

9. Birthplace: Cross Mineral County, W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: HENRY SUTTON
13. Birthplace: W.VA.

MOTHER
14. Maiden name: MARY JANE TASKER
15. Birthplace: W.VA.

16. Informant: William Brumage
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1945 (month) (day) (year)
Cemetery or crematory: Phelps Cem
Location: Westernport, Md.

18. Funeral director: E. Ellsworth S. Boal
Address: Westernport, Md.

19. Oct. 27, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 27 1945 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24 1945, to October 27 1945 and that I last saw her alive on October 27, 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Few min.
Due to: Coronary Arteriosclerosis	Yrs.
Due to: Diabetes Mellitus	Yrs.
Due to: Senescence	Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. H. Hendricks M. D. or other
Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

Dr. Brandt R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

09609

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred: 14 E. Second St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 E. Second St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Simon Seth Bryan

3.(b) Social Security Number: 212-24-0253

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Loretta McAuliff

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1885

8. AGE:

Years	Months	Days	If less than one day
60	0	2	hrs. min.

9. Birthplace: Saxton Bedford Pa.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Alfred E. Bryan

13. Birthplace: Saxton, Pa.

MOTHER

14. Maiden name: Emma Leonard

15. Birthplace: Yellow Creek, Pa.

16. Informant: Mrs. Martha Nickel

Address: 229 Oldtown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Oct 20, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1945, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1945 to October 18 1945; and that I last saw h[illegible] alive on October 18 1945.

	DURATION
Immediate cause of death: Ulcer of S. Stomach	1 year.
Due to: Hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.

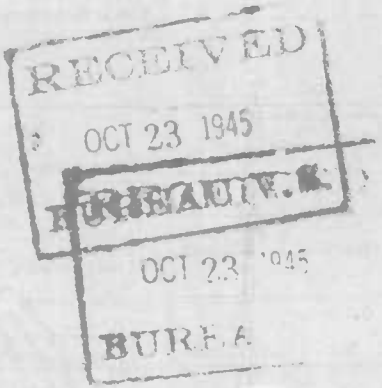
Address: [illegible] Date signed: 10-20-45

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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OCT 23 1945
BUREAU OF
OCT 23 1945
BUREAU

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Hawkins

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127a)

CERTIFICATE OF DEATH

09610

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Buffalo Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Ruie Burkett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Marion Burkett
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): February 9, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	7	25		

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Andrew Hillegass
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Lydia Hart
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7 1945 (month) (day) (year)
Cemetery or crematory: Dry Ridge Reformed
Location: Buffalo Mills, Pa.

18. Funeral director: Harvey L. Ziegler
Address: Hyndman, Pa.

19. Oct 6 1945 (Date rec'd by registrar) Wm. R. Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1945, at 4:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 1945 to Oct. 4 1945 and that I last saw h[illegible] alive on Oct. 4 1945

Immediate cause of death	DURATION
Lung Embolism	8 days
Due to: Gall Bladder	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Lapper M.D. M. D. or other
Address: Hyndman R Date signed: Oct 8 1945

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-E

CERTIFICATE OF DEATH

0611

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: allegany
City or town: cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: allegany Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DEACEASED: (For newborn infants give residence of mother)
State: md. County: allegany
City or town: Queen Mines (If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Ella Burke

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 26 — 1863

8. AGE: Years 81 | Months 9 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Co. Wexford Ireland (Town, county, and state)

10. Usual occupation home wife

11. Industry or business

FATHER 12. Name Patrick Burke
13. Birthplace Ireland

MOTHER 14. Maiden name Rose Kenny
15. Birthplace Ireland

16. Informant Mrs Martha Andrews
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4, 1945 (month) (day) (year)

Cemetery or crematory St. Michaels
Location Frostburg, Md.

18. Funeral director J. L. Duff
Address Frostburg md

19. Oct 3 1945 Winter L. Kantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1945, to Oct 2 1945 and that I last saw h.. alive on Oct 1 1945

Immediate cause of death	DURATION
Chronic dysentery, catarrhal;	about 2 or 3 months
Stool examination showed red blood	
Due to cells and pus cells	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other
Address 125 Bedford St Date signed 10/2/45


RECEIVED
OCT 9 1945
U.S.A.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

09612

★ Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred: 306 Waverly Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Waverly Terrace (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Giambattista Carpenti

3.(b) Social Security Number: 705-05-1699

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Amadio

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 23 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	8	23		

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Watchman B & O Ry

11. Industry or business: Retired

FATHER 12. Name: Peter Carpenti

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Clementine Landanese

MOTHER 15. Birthplace: Italy

16. Informant: Mrs Mary Carpenti

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem

Location: Cumberland

18. Funeral director: Lomo Stein Sons

Address: Cumberland

19. Oct 19, 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1945 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Oct 16 1945 and that I last saw h... alive on Oct 15 1945

Immediate cause of death	DURATION
Chronic Nephritis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: R. R. Swaakes M.D. M. D. or other

Address: Cumberland Md Date signed: Oct 18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

09613

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: B & O Ry Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Washington County: Snohomish

City or town: Everett (If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 4 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gustavus F. Chapman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown about 1892

8. AGE: Years: 53 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Col. U. S. Army

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant: Louis Stein Dec

Address: Cumberland, Md.

17. (Burial, cremation, or removal. Which?) Burial & Removal Date thereof: Oct 27 45 (month) (day) (year)

Cemetery or crematory: Arlington Cem.

Location: Washington D.C.

18. Funeral director: Louis Stein Dec

Address: Cumberland

19. (Date rec'd by registrar) Oct. 27 1945 Nate R Zantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24th, 1945, at 4.25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h... alive on ..... 19....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other coodilions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis H. Bolton M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 10-24-45

Deputy Medical Examiner - Allegany Co.

WITHIN CORPORATE LIMITS

DR. TELSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

09614

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 433 ASCENSION STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GUY H. COMBS

3.(b) Social Security Number 214-07-4380

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife GRADY, JESSIE

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) APRIL 9, 1897

8. AGE: Years	Months	Days	If less than one day
48	5	27	hrs. min.

9. Birthplace Moorefield, W. Va.
(Town, county, and state)

10. Usual occupation CELANESE

11. Industry or business

FATHER 12. Name COMBS, JOMBES

13. Birthplace W.VA.

MOTHER 14. Maiden name BEAN, MARTHA

15. Birthplace W.VA.

16. Informant Cpl. Earl Combs

Address Florida, Boca Batoa Field

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1945 (month) (day) (year)

Cemetery or crematory Hillcrest

Location Cumberland, Md.

18. Funeral director W. T. Leigler

Address Hyndman, Pa.

19. Oct 8 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 6, 1945 19 at 11:40 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-7- 1945 to 10-6 1945

and that I last saw h. alive on 10-5- 1945

Immediate cause of death	DURATION
Acute nephritis	about 2 months
Due to Periodontal abscesses probably	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Telson M.D. M. D. or other

Address Cumberland, Md. Date signed 10-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

09615

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yr.
Hospital, institution, or street address where death occurred:
101 Walnut
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Westernport - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. or R.F.D. No. 4 mi from Westernport on Accord Rumsey
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Cummings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James Cummings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9, 1859

8. AGE: Years 86 | Months 5 | Days 1 | If less than one day ....hrs. ....min.

9. Birthplace: Clarksburg-Harrison-W.Va.
(Town, county, and state)

10. Usual occupation: House wife.

11. Industry or business: Own-Home

FATHER
12. Name: Jacob Hershberger
13. Birthplace: Not known

MOTHER
14. Maiden name: Mary Casteel
15. Birthplace: Sang-Run, Md.

16. Informant: Mrs. Harry Warnick
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13, 45 (month) (day) (year)

Cemetery or crematory: Philos Cem.
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Oct 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10 1945 at 8.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15th 1945 to Oct 10 1945 and that I last saw her alive on Oct 9th 1945

Immediate cause of death	DURATION
Myocardial Degeneration,	4mo
Due to: Arterio Schlerosis.	5 yrs
Due to: Accidental fall. cvsb. Jun 15 1945	
Other conditions: Fracture of right hip joint Hemi Plegia Right side.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of June 15th, 1945.
Where did injury occur? Westernport (City or town) Allegany (County) Maryland (State)
Injured at home, farm, industry, public place (where?) At her home. Hilltop Drive.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Westernport, Md. Date signed: 10/20/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

09616

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 424 Seymour St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 424 Seymour St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Addie Kerns Cunningham

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Daniel Cunningham
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1873

8. AGE: Years	Months	Days	If less than one day
71	11	21	..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home

FATHER
12. Name Kerns
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Wm. A. Cunningham
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/45 (month) (day) (year)
Cemetery or crematory St. Patricks Cem.
Location Cumberland, Md.
18. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. Oct. 15 1945 Winter K. Gantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Oct 12 1945
and that I last saw h.. alive on October 11 1945

Immediate cause of death	DURATION
Myocarditis	2 yrs
Due to	
Due to	
Other conditions Diabetes Mellitus	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. D. Johnson Jr. M.D.
M. D. or other
Address Cumberland Md. Date signed 10-23-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

09617

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegheny
City or town: Cumberland 1st
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? 5 yrs —
Hospital, Institution, or street address where death occurred:
Res —
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 529 - Patterson ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Loston L. Dayton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Alsheretta
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 1 - 1873

8. AGE: Years: 72 | Months: 8 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Marshall Co. W. Va. (Town, county, and state)
10. Usual occupation: Retired Plumber
11. Industry or business: Plumber
FATHER 12. Name: James Dayton
13. Birthplace: W. Va -
MOTHER 14. Maiden name: Alice Pettit
15. Birthplace: W. Va -
18. Informant: C. P. Pearre
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-3-1945 (month) (day) (year)
Cemetery or crematory: Dickerson Runs Pa.
Location: Dickerson Runs Pa
18. Funeral director: B. M. Wade
Address: Bruceville, Penna.
19. Oct 3 1945 (Date rec'd by registrar) Witter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 - 1945 at 2 - A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 3 1945 to Oct. 3 1945
and that I last saw h... alive on Oct 3. 45 1945

Immediate cause of death	DURATION
Coronary Artery Disease	3 yr
Arteriosclerosis	
Due to	
Due to	
Other conditions Diabetes Mellitus	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. L. Pearre M.D.
Address: 126 Greene St Cumberland Md. M.D. or other
Date signed: Oct 4 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

09618

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Allegany

City or town: Corriganville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corriganville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miss Martha Elizabeth Delbrook

3.(b) Social Security Number: 213-16-4724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1878

8. AGE: Years	Months	Days	If less than one day
66	19	23	..... hrs. ..... min.

9. Birthplace: Wellersburg, Pa. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER 12. Name: Henry Delbrook

13. Birthplace: Pa.

MOTHER 14. Maiden name: Catherine Everline

15. Birthplace: Pa.

16. Informant: Harry Delbrook

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13, 1945 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Cumberland Md.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman? Pa.

19. Oct 13 1945 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 10 1945, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945, to Oct 10 1945, and that I last saw h alive on Oct 9 1945

Immediate cause of death	DURATION
Edwards Disease	
Due to: Carcinoma of Liver	6 mos
Due to: Carcinoma of Cecum and Transverse Colon	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Cecum and Transverse Colon Date of op. Jan 45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address [illegible] Date signed 10-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09619

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred: 404. Footer Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 404. Footer Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma Virginia DeMoss

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry DeMoss

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): February 22 1868

8. AGE: Years	Months	Days	If less than one day
77	8	6	hrs. min.

9. Birthplace: Winchester, Va.
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER 12. Name: Anthony Chrismore

FATHER 13. Birthplace: Winchester, Va.

MOTHER 14. Maiden name: Elmira Vohon

MOTHER 15. Birthplace: Winchester, Va.

18. Informant: Miss Mildred DeMoss

Address: 404. Footer Place, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 29, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1945, at 1-30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Oct 28 1945 and that I last saw h[illegible] alive on Oct 28 1945

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to	
Due to	
Other conditions Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. H. Weathers M. D. or other

Address: 49 Greene St. Date signed: 10-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

69620

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 135 Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Infant boy Di Chiera

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1945.

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 30 min.

9. Birthplace: Westernport, Allegany-Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name: Virginia Di Chiera
15. Birthplace: Luke, Md.

16. Informant: Stella Di Chiera
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1945. (month) (day) (year)
Cemetery or crematory: St. Peters Cemetery
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Oct 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22, 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1945 to Oct 22 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Premature ety (6 mo)	
Due to Premature Separation of Placenta	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Norman Reese, Jr. M.D.
M. D. or other
Address: Westernport, Md. Date signed 10-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 Years

Hospital, Institution, or street address where death occurred: 256. Columbia St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 256. Columbia St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Floraelle Dowlan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James S. Dowlan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 8 1861

8. AGE: Years	Months	Days	If less than one day
83	11	24	..... hrs. ..... min.

9. Birthplace: Martinsburg, Morgan Co, West Va (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER — 12. Name: John Bateman

FATHER — 13. Birthplace: Martinsburg, W. Va.

MOTHER — 14. Maiden name: Anna Matthews

MOTHER — 15. Birthplace: Martinsburg, W. Va.

16. Informant: Stoner S. Dowlan

Address: 514. Hill Top Drive, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: Willian H. Kight

Address: Cumberland, Md.

19. Oct. 3, 1945 (Date rec'd by registrar) Walter P. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1945, at 7-45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1945 to Oct. 2 1945

and that I last saw h... alive on Sept 25 1945

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	
Due to Chronic nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. N. Hodges, M.D. M. D. or other

Address: Oct. 2, '45 Cumberland, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

CERTIFICATE OF DEATH

09622

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 45 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16. Altamont Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rose Drawbaugh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward C. Drawbaugh

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): March 15 1873

8. AGE: Years	Months	Days	If less than one day
72	6	26	...hrs. ...min.

9. Birthplace: Shepardstown, Jefferson Co, W. Va.
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER
12. Name: M. J. Billmyer
13. Birthplace: Shepardstown, W. Va.

MOTHER
14. Maiden name: Elizabeth VanMeter
15. Birthplace: Shepardstown, W. Va.

16. Informant: Edward C. Drawbaugh
Address: 16. Altamont Terr, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/13/45 (month) (day) (year)

Cemetery or crematory: Elmwood Cemetery

Location: Shepardstown, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 17 1945 (Date rec'd by registrar) Winta R. Mauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 19 45, at 12-15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-24-45 19... to 10-11-45 19...
and that I last saw h... alive on 10-11-45 19...

Immediate cause of death	DURATION
Cerebrovascular Accident	6 mos.
Due to	
Due to	
Other conditions: Carcinomatosis	6 wks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Zimmerman M.D. M. D. or other

Address: Date signed 10-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09623

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Richard Dunn

3. (b) Social Security Number 212-10-9142

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: mary Dunn
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): September 1, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	23	hrs. min.

9. Birthplace: Mt. Savage Allegany Cty, Md.
(Town, county, and state)
10. Usual occupation: miner
11. Industry or business: Coal mines
FATHER 12. Name: Thomas Dunn
13. Birthplace: unknown
MOTHER 14. Maiden name: Mary Hummer
15. Birthplace: Maryland
18. Informant: Mrs. Mary Dunn
Address: Mt. Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 26 1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage Md.
18. Funeral director: J. J. Quirst
Address: Frostburg, Md.
19. 10-24 19 45 (Date rec'd by registrar) Thomas M. Dennith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 24th 19 45 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from, October 19 44, to Octob 24th 19 45 and that I last saw him alive on Octob 24th 19 45

Immediate cause of death	DURATION
Myocarditis	5 years
Due to: Chronic Bronchial asthma	7-8 years
Due to:	
Other conditions: Pulmonary Oedema	6-8 weeks

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M. D. or other
Address: Mt Savage Md. Date signed 10-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

09624

CERTIFICATE OF DEATH

★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 59 Braddock St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Wesley Elrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Agnes R. Thompson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 4 - 1888

8. AGE:

Years	Months	Days	If less than one day
57	1	18	..... hrs. ..... min.

9. Birthplace Thomas W. Va. (Town, county, and state)

10. Usual occupation Assistant Machinist

11. Industry or business Balastic Plant

FATHER 12. Name John Elrick

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden name Isabelle Sturtz

MOTHER 15. Birthplace Pa.

16. Informant Mrs. Jos. Elrick

Address 54 Grand St. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 - 25 - 1945 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob A. Kafer

Address Frostburg, Md.

19. 10 - 24 1945 Mrs. Nancy A. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at 4 02 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/21 1945 to 10/22 1945

and that I last saw h.. alive on 10/21 1945

Immediate cause of death Rt lobar pneumonia — DURATION 3 days

Due to .....

Due to .....

Other conditions Bronchial asthma

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hilda Jane Walter M.D.

M. D. or Coroner

Address Frostburg Date signed 10/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

CERTIFICATE OF DEATH

09625

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Narrows Pk.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sandra Kay Engle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 17, 1945

8. AGE: Years	Months	Days	If less than one day
	2 mo.	8	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)
10. Usual occupation Infant
11. Industry or business
FATHER 12. Name Charles Boyd Judy
13. Birthplace ?
MOTHER 14. Maiden name Dorothy Engle
15. Birthplace Md.
18. Informant Dorothy Engle
Address Route 1, Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Cumberland Md
18. Funeral director John J. Hafer
Address Cumberland, Md

19. Oct. 27 1945 (Date rec'd by registrar) Nate A Dant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1945, at 6:04 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24 1945, to October 25 1945 and that I last saw her alive on Oct. 25 1945

Immediate cause of death Infectious diarrhea — DURATION 1 day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elizabeth Bruce M.D.
M. D. or other
Address Loup, Md. Date signed 10/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

09626

★ Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1/4 Mi. from limits
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Arthur Freeman Everts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Everts
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 7, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	13	....hrs. ....min.

9. Birthplace: Gorman-Garrett-Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Tenant farmer
FATHER 12. Name: John A. Everts
13. Birthplace: Bedford., Pa.
MOTHER 14. Maiden name: Margaret Knnepp
15. Birthplace: Maryland.
16. Informant: Mrs. Minnie Everts
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23, 45. (month) (day) (year)
Cemetery or crematory: Fairview Cemetery.
Location: 4 Mi. S.W. of Gorman, Md.
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.
19. Oct. 22 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20, 19 45 at 8p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to Oct 20 19 45
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Sarcoma of rt. Ethmoid	2 yrs.
Sinus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas Keener M.D
M. D. or other
Address: Westernport Md Date signed 10-21-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09627

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 mos.

Hospital, institution, or street address where death occurred: 812 Buckingham Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 812 Buckingham Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Footer

3.(b) Social Security Number 212-12-8724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife Mary E. Turner

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 17 1867

8. AGE: Years	Months	Days	If less than one day
78	5	18	hrs. min.

9. Birthplace Yorkshire, England (Town, county, and state)

10. Usual occupation Banker

11. Industry or business

FATHER 12. Name Thomas Footer

13. Birthplace England.

MOTHER 14. Maiden name Elizabeth Booth

15. Birthplace England.

16. Informant Mrs Albert Kuyser

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Jr.

Address Cumberland.

19. Oct. 4 1945 (Date rec'd by registrar) Hunter R. Scott M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18, 1945, to Oct. 1, 1945 and that I last saw h[illegible] alive on October 1, 1945

Immediate cause of death	DURATION
Acute Myocardial Failure	1 day
Due to Severe Myocardial Infarction	2 days
Due to Coronary Occlusion	??
Due to Left Bundle Branch Block	??
Other conditions Heart Block	??

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leonard Jacobson M.D. M. D. or other

Address 14 S. Liberty St. Date signed 10/2/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09628

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs
Hospital, institution, or street address where death occurred: 506 Rose Hill Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 506 Rose Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ida W Frantz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John A Frantz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 1858

8. AGE:

Years	Months	Days	If less than one day
87	3	18	hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: George Winters
13. Birthplace: Md.
MOTHER 14. Maiden name: Sarah Coombs.
15. Birthplace: Md
16. Informant: Dr. Winter Frantz
Address: Cumberland
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 30 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland.
19. Oct. 29 1945 (Date rec'd by registrar) Winter P. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1945, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to Oct 28 1945 and that I last saw h alive on Oct 28 1945

Immediate cause of death	DURATION
Chronic Hypocondilitis	
Due to	
Due to	
Other conditions Pancreas Pt leg. due to Endarteritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R B Meerstein M. D. or other
Address: 49 Greene St Date signed: 10/29/45

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

09629

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINA County PRESTON

City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

REV. FLOYD , L. FULTZ

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MRS. ~~Phillips Fultz~~ PHILLIPS

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) FEB. 9, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	3	hrs. min.

9. Birthplace WEST VIRGINA
(Town, county, and state)

10. Usual occupation MINISTER

11. Industry or business

FATHER
12. Name O. H. FULTZ
13. Birthplace WEST VIRGINA

MOTHER
14. Maiden name ETTA REEDER
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 13. 45 (month) (day) (year)

Cemetery or ~~Crematory~~ Buckhannon, W. Va.

Location Buckhannon W Va.

18. Funeral director G. F. Collins

Address Terra alta W Va.

19. Oct. 13 1945 Winter R. Fultz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 12 19 45 at 11:55P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8. 1945, to Oct. 12. 1945 and that I last saw him alive on Oct. 12. 1945

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to	
Due to Coronary Arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 10/13/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

09630 4
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
50 N. Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 50 N Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war 1st World War

3.(a) FULL NAME Cecil Jeremiah Garlitz

3.(b) Social Security Number 216-18-1183

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Dolorosa Barba
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1896

8. AGE: Years	Months	Days	If less than one day
49	7	23	hrs. min.

9. Birthplace Frostburg Md
(Town, county, and state)
10. Usual occupation Bar Tender
11. Industry or business
FATHER 12. Name Enoch A. Garlitz
13. Birthplace Arilton Md.
MOTHER 14. Maiden name Agnes C. Mc Kenzie
15. Birthplace Finzel Md.
16. Informant Paul H. Garlitz
Address Mt Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18 '45 (month) (day) (year)
Cemetery or crematory St Michaels Cem
Location Frostburg Md.
18. Funeral director Louis Stein Inc.
Address Cumberland Md.
19. Oct. 17 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH October 15th, 1945, at 1 [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---
Date of op.
Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul H. Garlitz M.D.
Address Cumberland, Maryland M. D. or other
Date signed 10-15-45

09631

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 yrs
Hospital, Institution, or street address where death occurred: Douglas Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Douglas Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Elijah Gould

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 25, 1868.

8. AGE:

Years	Months	Days	If less than one day
77	4	15	hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Laborer Retired
11. Industry or business: Sewage Septic Tank
FATHER 12. Name: Elijah Gould
13. Birthplace: England
MOTHER 14. Maiden name: Annie Ball
15. Birthplace: England
16. Informant: Miss Sara Gould
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing Md.
18. Funeral director: M. E. Eichhorn
Address: Lonaconing, Md.
19. Oct 13 1945 Dr. E. Dan'l Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16, 1945, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5th 1945, to Oct 10 1945
and that I last saw h. alive on Oct. 9th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Henry Dr. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: Oct. 13th 45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

09632

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 508 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 508 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Grunfield

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Joseph Grunfield

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 6 1855

8. AGE:

Years	Months	Days	If less than one day
90	9	22	..... hrs. ..... min.

9. Birthplace: W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Charles G. Bowers

13. Birthplace: Va.

MOTHER

14. Maiden name: Mary P. Parsons

15. Birthplace: W. Va.

16. Informant: Mrs. Kate Lintelman

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland

18. Funeral director: Louis Stein Sons

Address: Cumberland.

19. Oct. 29 1945 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1945, to Oct 28 1945

and that I last saw her alive on Oct 27 1945

Immediate cause of death	DURATION
Uremia Coma	1 Day
Due to: Nephritis Chronic	2 yrs
Due to: Infirmities of Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos A Thomas M. D. or other

Address: Cumberland Md Date signed 4-13

WITHIN CORPORATE LIMITS

Rawlings Grove

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

09633

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, institution, or street address where death occurred 374 N. Centre St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 374 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary T. Habig

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Damian Habig
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 3 1861

8. AGE: Years 84 | Months 7 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Michael Steigmaier
13. Birthplace Germany

MOTHER
14. Maiden name T— Hillet
15. Birthplace Germany

16. Informant Tirza M. Habig
Address Cumberland

17. Buried Date thereof Oct 23 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Peter & Pauls Cem.
Location Cumberland.

18. Funeral director Louis Stein Inc.
Address Cumberland

19. Oct 22, 1945 Miles K. Beauty M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1945 at 3 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 27 1945 to Oct. 21, 1945
and that I last saw h. C.R. alive on Oct 19 1945

Immediate cause of death	DURATION
anterior poliomyelitis	
Due to cardio-vascular disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. B. Moore M.D.
M. D. or other
Address Medical Bldg Date signed 10-22-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09634

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Franklin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Franklin
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 mile N. of Westernport, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Amanda Frances Hamilton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William A. Hamilton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 26, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	20	..... hrs. ..... min.

9. Birthplace: Franklin-Allegany-Md.
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Own-Home

FATHER
12. Name: David Randalls
13. Birthplace: Keyser, W.Va.

MOTHER
14. Maiden name: Rebecca Carver
15. Birthplace: Virginia

16. Informant: Mr. David Hamilton
Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19 45. (month) (day) (year)
Cemetery or crematory: Philos. Cem.
Location: Westernport, Md.
18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. Oct. 18 19 45 — Registration Dist. No. [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 19 45, at 9.15a.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 45, to Oct. 16 19 45
and that I last saw h.er alive on Oct - 16 19 45

Immediate cause of death	DURATION
Myocarditis	3 days
Due to Senile Hypertension	
Condition Stenosis	
Due to Renal Disease	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Berry Fox M.D. or other
Address: Piedmont W.Va. Date signed: 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09635

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Years

Hospital, Institution, or street address where death occurred: North Branch, R. F. D. # 4.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural, R.F.D. #4. North Branch

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Henry Hamilton

3.(b) Social Security Number: 705-09-4850

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lorena Hamilton

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): August 13 1874

8. AGE: Years	Months	Days	If less than one day
71	2	5	hrs. min.

9. Birthplace: Orleans Cross Roads, Morgan Co, W.Va. (Town, county, and state)

10. Usual occupation: Telegraph Operator

11. Industry or business: Baltimore & Ohio Railroad

FATHER — 12. Name: Charles E. Hamilton

FATHER — 13. Birthplace: Orleans Cross Roads, W. Va.

MOTHER — 14. Maiden name: Elizabeth Ashkettle

MOTHER — 15. Birthplace: Little Orleans, Md.

16. Informant: Raymond W. Hamilton

Address: 509, Prince George St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/20/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 20, 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1945, at 12-05A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 17. 1945 to Oct. 18, 1945 and that I last saw him alive on Oct. 17, 1945

	DURATION
Immediate cause of death: Uraemia	2 wks
Due to: Congestion	6 mos
Due to: Arteriosclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clark Turner M. D. or other

Address: Cumberland Date signed: Oct 18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

09636

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: 111 West 2nd St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 W. 2nd St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Estella A Hansel

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph W. Hansel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 2 1876

8. AGE: Years	Months	Days	If less than one day
69	—	7	hrs. min.

9. Birthplace: Great Cacapon W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at Home
12. Name of Father: Levi Whissen
13. Birthplace of Father: W. Va.
14. Maiden name of Mother: Agnes Eversole
15. Birthplace of Mother: W. Va.
16. Informant: Jos. W. Hansel
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland
18. Funeral director: Louis Stein Sons
Address: Cumberland
19. Oct. 11, 1945 Walter R. Beauty M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1945 at 6 30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1942 to Oct 9 1945
and that I last saw h alive on Oct 9 1945

Immediate cause of death	DURATION
Coronary Arterial Thrombosis	5 hr.
Due to: Chronic Myocarditis	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. S. Blevins M. D. or other
Address: 133 Va Ave Date signed: 10/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

09637

★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 Mc Cullough

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry Harris

3.(b) Social Security Number: 219-01-3149

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Margret Harris

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Sept 29 - 1877

8. AGE: Years: 68 | Months: 0 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Jersey City (town, county, and state) N.J.

10. Usual occupation: retired laborer

11. Industry or business

FATHER — 12. Name: Wm Harris

13. Birthplace: England

MOTHER — 14. Maiden name: Catherine Coates

15. Birthplace: md.

16. Informant: Geo Harris

Address: Frostburg md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 - 1945 (month) (day) (year)

Cemetery or ~~cremetery~~: St. Michaels

Location: Frostburg

18. Funeral director: J Pedusti

Address: Frostburg md.

19. 10-30 1945 Mrs. Stanley N. Poe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1945, at 11 30/60 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/18 1945, to 10/28 1945 and that I last saw h[im] alive on 10/28 1945

Immediate cause of death	DURATION
Surgical Shock	4 hrs
Due to: Evisceration from ruptured intestine	4 hrs
Due to: Cholecystectomy for subacute cholecystitis & stones.	6 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: subacute cholecystitis & lithiasis Date of op. 10/25/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jourdet Hay M.D.

M. D. or other

Address: Frostburg Md Date signed: 10/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9:40 A.M. passed away

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

09638

Reg. Diat. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Piney Grove
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 years

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Piney Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Eugenie Fletcher Hartley

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George M. Hartley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	9	..... hrs. ..... min.

9. Birthplace Clearidge, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Fletcher
13. Birthplace unknown

MOTHER
14. Maiden name Susan Ann O'Neal
15. Birthplace unknown

16. Informant Mrs. Ethel Fletcher
Address Cumberland, Md.

17. Burial Date thereof Oct. 14, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~ Piney Plains Methodist Church

Location Piney Plains, Md.

18. Funeral director Charles R. Bast

Address Hancock, Md.

19. Oct 14 1945 T. T. Mumma Asst. M.E. Mum
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1945, at 9:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, 19.., to Oct. 12 1945

and that I last saw her alive on Oct. 11, 1945

Immediate cause of death	DURATION
Diabetic Coma	7 days
Due to Diabetes Mellitus	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Watson M.D.
M. D. or other

Address Little Orleans, Md. Date signed 10/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09639

CERTIFICATE OF DEATH

★ Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Western Port
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Reeves Clinic
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)
Street No. (R#3 Keyser, W.Va.)
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Harry Frederick High

3. (b) Social Security Number
236-12-9398

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Flora Arnold High
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 9th. 1888

8. AGE: Years	Months	Days	If less than one day
57	2	11	..... hrs. ..... min.

9. Birthplace Purgittsville, Hamp. Co. W.Va. (Town, county, and state)
10. Usual occupation Merchant, retired
11. Industry or business
FATHER 12. Name John Harper High
13. Birthplace Purgittsville, W.Va.
MOTHER 14. Maiden name Sarah Laner Huffman
15. Birthplace Purgittsville, W.Va.
16. Informant Lawrence A. High
Address Purgittsville, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-45 (month) (day) (year)
Cemetery or crematory High Family Cemetery
Location Purgittsville, W.Va.
18. Funeral director N.L. Rogers Funeral Directors
Address Keyser, W.Va.
19. Oct 23 19 45 — (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20th. 1945, at 2.30 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/20 45 to 10/20 45 and that I last saw him alive on 10/20/45 19.....

Immediate cause of death	DURATION
acute Myocardial failure	instant
Due to	
Due to Chr. Myocarditis Bronchial asthma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C W Reeves M.D. M. D. or other
Address Westernport Md Date signed 10/20/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09640

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1929

Hospital, institution, or street address where death occurred: 762 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 762 Fayette St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Rankin Holland Sr.

3.(b) Social Security Number: 214-07-6076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Brandes Holland

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): April 15, 1881

8. AGE: Years	Months	Days	If less than one day
64	6	12	...hrs. ...min.

9. Birthplace: Charlotte, N.C. (Town, county, and state)

10. Usual occupation: Supt. Of Chemical Division

11. Industry or business: Celeanese Corp. of America

FATHER
12. Name: James R. Holland
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Orleona Estelle Shaw
15. Birthplace: Pennsylvania

16. Informant: Mrs. Alice Holland

Address: 762 Fayette St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct 30 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1945, at 4a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-6- 1943, to Oct-28 1945 and that I last saw h... alive on 5.21. 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Due to
Due to Coronary Sclerosis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or Coroner

Address: Cumberland Date signed: 10-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

09641

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred: 61 W. Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 61 West Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Hoskens

3.(b) Social Security Number: 220-03-7036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78		23		

9. Birthplace: Frostburg Allegany Co. Md.
(City, county, and state)
10. Usual occupation: Sales Lady - Retired
11. Industry or business: none

FATHER
12. Name: George Hoskens
13. Birthplace: Cornwall England

MOTHER
14. Maiden name: Hannah Kear
15. Birthplace: Glostershire England

16. Informant: Kear Hoskens
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.

19. 10-21 1945 M. Stanley V. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1945, at 7 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6 1942 to 10/19 1945
and that I last saw h. alive on 10/18 1945

Immediate cause of death	DURATION
Coronary Thrombosis	18 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walters M.D.
M.D. or other
Address: Frostburg, Md. Date signed: 10/20/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

09642

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40. Years

Hospital, Institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 40. Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Wood Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary C. Howard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James Howard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 15, 1878

8. AGE: Years	Months	Days	If less than one day
67	5	7	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Germany

18. Informant: James Howard, Jr.

Address: 311. Rock St, Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/45 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 25, 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1944, to Oct 22 1945 and that I last saw her alive on Oct. 20 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to Infirmities of age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 10-23-45

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MC)

09643

CERTIFICATE OF DEATH

★ Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany County
City or town Route 40, 6 miles west Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war Second World War

3.(a) FULL NAME William Cecil Humbertson

3.(b) Social Security Number 213-18-2703

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1915

8. AGE: Years	Months	Days	If less than one day
30	6	25	hrs. min.

9. Birthplace Eckhart, Allegany Cty., Md. (Town, county, and state)
10. Usual occupation silk worker
11. Industry or business Celanese plant
FATHER 12. Name Jerome Humbertson,
13. Birthplace Frostburg, Md.
MOTHER 14. Maiden name Elva Porter,
15. Birthplace Eckhart, Md.
16. Informant Jerome Humbertson,
Address Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1945 (month) (day) (year)
Cemetery or crematory Porter Cemetery,
Location Eckhart, Md.
18. Funeral director J. J. Durst,
Address Frostburg, Md.
19. Oct. 31, 1945 (Date rec'd by registrar) Witter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 28th, 1945 at 12.50 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured first and second cervical vertebrae	5 min.
Due to (Comp. fracture left tibia, middle third; fract. left fibula	
Due to middle third; lacerations and brush burns	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ----
Date of op.
Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide under investigation Date of 10/28/45
Where did injury occur? near Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway # 40
Means of injury struck by auto Injured at work? no

23. SIGNATURE Lewis H. Bowen, M.D.
M. D. or other
Address Cumberland, Maryland Date signed 10/28/45
Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegheny County
City or town: Cresaptown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Harrison Johnson.

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida May Johnson
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): December 1 1866

8. AGE: Years	Months	Days	If less than one day
78	10	26	...hrs. ...min.

9. Birthplace: Garrett County, Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: Cornelius Johnson
FATHER 13. Birthplace: Garrett County
MOTHER 14. Maiden name: Catherine Overholtz
MOTHER 15. Birthplace: Pennsylvania
18. Informant: Mrs. L. L. Wolfenbarger
Address: Cresaptown Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 28/45 (month) (day) (year)
Cemetery or crematory: Oakland Cem.
Location: Oakland, Md.
18. Funeral director: Emmert D. Coldiron
Address: Oakland Md.
19. Oct 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1942, to October 26 1945 and that I last saw h... alive on October 25 1945

Immediate cause of death	DURATION
congestive heart failure	6 months
Due to: chronic myocarditis	3 years
Due to:	
Other conditions: cancer of the prostate	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Briggs M.D. M. D. or other
Address: Lonaconing Md. Date signed: 10-26-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09645

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64. Years

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 928. Glenwood St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Viola Jones

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6 1881

8. AGE: Years	Months	Days	If less than one day
64	5	0	hrs. min.

9. Birthplace: Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER
12. Name: James Jones
13. Birthplace: Roanoke, Va.

MOTHER
14. Maiden name: Amanda Crupper
15. Birthplace: Roanoke, Va.

16. Informant: Mrs. Vance Robinson
Address: 136. Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/45 (month) (day) (year)

Cemetery or crematory: Trinity Luthern Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 9 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1945, at 7-55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to Oct 6 1945

and that I last saw h[illegible] alive on Oct 6 1945

Immediate cause of death	DURATION
Malignancy of liver primary?	2 mo(?)
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lizzie R. Everhart M.D.
M. D. or other

Address: 26 Greene St Date signed: 10/9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09646

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Dist.

(If outside city or town limits, write RURAL, and give nearest town)

Street No. 61 Frost Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Catherine Knight

3.(b) Social Security Number V

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Harry L. Knight

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25 1872

8. AGE: Years 73 | Months 2 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Home Maker

11. Industry or business

FATHER 12. Name: Frederick Koontz

13. Birthplace: Germany

MOTHER 14. Maiden name: Margaret Barnes

15. Birthplace: Frostburg, Md.

16. Informant: Mrs. Fred Bortmes

Address: 5 E. W. Loos St, Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Bafer

Address: Frostburg, Md.

19. 10-13 (Date rec'd by registrar) 1945 Murray L. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 10 1945 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 4 1945 to Oct 10 1945 and that I last saw h.er alive on Oct 10 1945

Immediate cause of death: Chronic myocarditis — DURATION: Several years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane M.D. M. D. or other

Address: Frostburg Md. Date signed 10-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115)

CERTIFICATE OF DEATH

09647

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 44 MARIAN ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MR LOYAL LANE

3. (b) Social Security Number: 214-07-1938

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ANNA EVANS
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): August 25 1893

8. AGE: Years	Months	Days	If less than one day
52	2	0	...hrs. ...min.

9. Birthplace: MD. Lonaconing, Allegany Co (Town, county, and state)
10. Usual occupation: CELANESE PLANT
11. Industry or business: Fireman

FATHER
12. Name: ROBERT LANE
13. Birthplace: MD. Lonaconing

MOTHER
14. Maiden name: ELIZ JACKSON
15. Birthplace: Lonaconing Md

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/28/45 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Md.
18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Oct. 27 1945 (Date rec'd by registrar) Winter R. Brant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 25, 1945 at 6:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1945, to Oct 25 1945, and that I last saw h... alive on Oct 24 1945

Immediate cause of death	DURATION
Coronary Occlusion	3 days
Due to Acute Nephritis	1 week
Due to Acute Pleurisy with Effusion	2 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed Oct 26 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-4)

CERTIFICATE OF DEATH

09648 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 36, Greene St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Lashley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Thomas B. Lashley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 29 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	1	2		

9. Birthplace: Westernport, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER — 12. Name: Samueal Evans

FATHER — 13. Birthplace: Elkton, Md.

MOTHER — 14. Maiden name: Rebecca Kight

MOTHER — 15. Birthplace: Westernport, Md.

16. Informant: Lynn C. Lashley

Address: 1901. Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoluem

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 2, 1945 (Date rec'd by registrar) Winter R. Bauch, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1945 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to October 31 1945 and that I last saw her alive on October 31 1945

Immediate cause of death: Enlargement of Liver & Hepatitis — DURATION: 3 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James T. Johnson M.D. M. D. or other

Address: Cumberland Md. Date signed: 11-1-45

WITHIN CORPORATE LIMITS
Dr. Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (310)

CERTIFICATE OF DEATH

09649

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
32 N. Lee St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany.
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 Vine St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Margaret Elizabeth Lease

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm Lease
6.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) Aug 10, 1865

8. AGE: Years	Months	Days	If less than one day
80	2	1	hrs. min.

9. Birthplace Rawlings, Allegany Co, Md (town, county, and state)
10. Usual occupation Housework
11. Industry or business At Home

FATHER
12. Name Silas Mc Kenzie
13. Birthplace Ohama, Nebraska

MOTHER
14. Maiden name Sarah Spencer
15. Birthplace Nubely Mts, W. Va.

16. Informant William Lease
Address 32 N. Lee St, Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13 1945 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland Md
18. Funeral director John J Hafer
Address Cumberland, Md.
19. Oct. 13, 1945 Witter R Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1945, at 12:40 AM
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct. 7 1945, to Oct. 11 1945
and that I last saw h.er alive on Oct. 10, 1945 1945

	DURATION
Immediate cause of death Coronary Thrombosis	1 week.
Due to Hypertensive Cardio-Vascular Renal Disease	10 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Blore M. Schindler MD M. D. or other
Address 41 Greene St Date signed Oct 13 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

09650 8

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: Charlestown Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Charlestown St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Steele Lease

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John H. Lease
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): [illegible] - [illegible] - 1873

8. AGE: Years: 72 | Months: - | Days: - | If less than one day: hrs. min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: Own Home

FATHER
12. Name: Thos. Steele
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Scotland

16. Informant: Jno. H. Lease
Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 19 1945 (month) (day) (year).
Cemetery or crematory: Steele Burying Ground
Location: Near Lonaconing

18. Funeral director: M. Eichhorn
Address: Lonaconing Md

19. Oct 18 1945 (Date rec'd by registrar) Dr. E. Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1945, at 8.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 [illegible], to [illegible] 19 [illegible]
and that I last saw her alive on Oct. 17th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. E. Dorsey M. D. or other
Address: Lonaconing Date signed: Oct 18 1945

WITHIN CORPORATE LIMITS

DATE GRATIS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1172)

CERTIFICATE OF DEATH

09651

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 43 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: MINERAL
City or town: KEYSER
(If outside city or town limits, write RURAL and give nearest town)
Street No. 98 B STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. LESLIE LEATHERMAN

3.(b) Social Security Number: 233-09-0263

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JUNE 18, 1901

8. AGE: Years: 44 | Months: 4 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA, Mineral County
(Town, county, and state)

10. Usual occupation: LABORER

11. Industry or business: City of Keyser W. Va.

FATHER
12. Name: ROBERT LEATHERMAN
13. Birthplace: WEST VIRGINIA, Hampshire Co.

MOTHER
14. Maiden name: MARY FRANCES BARR
15. Birthplace: WEST VIRGINIA, Gore

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24, 1945 (month) (day) (year)
Cemetery or crematory: Dulin's Cem
Location: Rural-Keyser, W. Va.

18. Funeral director: W. L. Rogers
Address: Keyser, W. Va.

19. Oct. 22, 1945 (Date rec'd by registrar) Winter R. Crawley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 22, 1945 1:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 9, 1945 to OCT. 22, 1945 and that I last saw him alive on Oct 22 OCT. 22, 1945

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to: Gastric Ulcers	
Due to: Gastric perforation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gastric ulcers
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: H. G. Grace M. D. or other
Address: Cumberland Md. Date signed Oct 22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

09652

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany County

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Willowbrook Rd. Rt. # 2
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland, rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lula Mallow

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife Alvin Mallow

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 16, 1884

8. AGE: Years	Months	Days	If less than one day
61	7	0	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name ?

15. Birthplace

18. Informant Alvin Mallow

Address Rt. 2, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1945 (month) (day) (year)

Cemetery or crematory Oakdale Methodist Cemetery

Location Near Flintstone, Md

18. Funeral director Ray J. Hafer

Address Cumberland, Md

19. Oct. 19, (Date rec'd by registrar) 19 45 Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 45, at 8:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-23 19 45, to 10-16 19 45

and that I last saw her alive on 10-16 19 45

	DURATION
Immediate cause of death: Fracture left femur	23 days
Due to:	
Due to:	
Other conditions: Diabetis Melletus	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-23-45

Where did injury occur? Clearville, Bedford, Pa.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fell while walking Injured at work? No

23. SIGNATURE James T. Johnson Jr. M.D.
M. D. or other

Address Cumberland, Md. Date signed 10-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09633

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs.

Hospital, institution, or street address where death occurred: 477 Lena St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 477 Lena St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Catherine L. Marean

3. (b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Albert E Marean

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 4 1867

8. AGE:

Years	Months	Days	If less than one day
78	6	26	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Martin Rankin
13. Birthplace: Germany

MOTHER
14. Maiden name: Annie C. Herpich
15. Birthplace: Germany

16. Informant: John Marean
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 3 '45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland

18. Funeral director: Louis Stein & Sons
Address: Cumberland

19. Oct 2 1945 (Date rec'd by registrar) Miles L. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 1945 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Oct 1 1945 and that I last saw her alive on Oct 1, 1945

	DURATION
Immediate cause of death: Organic Heart Disease, Angina Pectoris	24 hrs
Due to: Chronic Nephritis	24 hrs
Due to: Arterio Sclerosis	24 hrs
Other conditions: Paralysis on Right Side	24 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas A Lowe M. D. or other

Address: Cumberland Md Date signed: 10-3-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

09654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, Institution, or street address where death occurred:

5 Laing Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Laing Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Pearl Frances Maxwell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas Maxwell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	18	..... hrs. ..... min.

9. Birthplace Oakland Garrett Co Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Wm Jacob Saunders

13. Birthplace W. Va

MOTHER 14. Maiden name Margaret Welch

15. Birthplace Illinois

16. Informant Glenwood Miller

Address 1241 - 6th St S.W. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19, 1945 (month) (day) (year)

Cemetery or crematory Queens Point Cemetery

Location Keyser W. Va.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Oct. 19, 1945 (Date rec'd by registrar) Walter L. Haun M.D. Registrar

Schindler

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1945, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17, 1945, to Oct 17, 1945

and that I last saw h... alive on ..... 19....

Immediate cause of death	DURATION
Coronary Thrombosis	2 hours
Due to Hypertensive Cardiovascular Renal disease	10+ years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blanche M. Schindler M. D. or other

Address 41 Greene St Date signed Oct. 18, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09655

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Route 1 Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Route 1 Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World war

3. (a) FULL NAME: William McKee McKenzie

3. (b) Social Security Number: 220-10-2749

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Bessie McKenzie
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): December 23 1888

8. AGE: Years	Months	Days	If less than one day
56	9	15	hrs. min.

9. Birthplace: Borden Shaft Allegany Cty Md
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: WPA project
12. Name of father: John F. McKenzie
13. Birthplace of father: Maryland
14. Maiden name of mother: Annie J. Loar
15. Birthplace of mother: Maryland
16. Informant: Mrs Wm Cunningham
Address: Lord, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md
18. Funeral director: J. J. Dolrist
Address: Frostburg Md.
19. 10-10 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1945, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.. to Oct 9 1945
and that I last saw him alive on Oct 8 19..

Immediate cause of death: Chronic Myocarditis — DURATION: several years
Due to: Bronchitis — several years
Due to: acute
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: 10-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94f)

CERTIFICATE OF DEATH

09656

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME George William Merica

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Annie Virginia Merica

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1860

8. AGE: Years	Months	Days	If less than one day
85	0	22	...hrs. ...min.

9. Birthplace Shenandoah City, Page Co., Va. (Town, county, and state)

10. Usual occupation Railroader

11. Industry or business —

FATHER 12. Name David Merica

13. Birthplace Shenandoah City, Va.

MOTHER 14. Maiden name Annie Virginia Baker

15. Birthplace Shenandoah City, Va.

16. Informant John T. Merica

Address Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1945 (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location

18. Funeral director Charles R. Bast

Address Hancock, Md.

19. Oct 10 1945 (Date rec'd by registrar) T. T. Mannspeaker M.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1945 to Oct. 8, 1945 and that I last saw him alive on Oct. 7, 1945

Immediate cause of death	DURATION
Angina pectoris	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Watson M. D. M. D. or other

Address Little Orleans, Md. Date signed Oct. 9, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

09657

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry R. Middleton

3. (b) Social Security Number 213-10-5287

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 4 1889

8. AGE: Years 56 | Months 11 | Days 27 | If less than one day ..... hrs. ..... min.

8. Birthplace Barrelsville, Allegany, Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Mine

FATHER 12. Name Robert Middleton

13. Birthplace Flintstone, Md.

MOTHER 14. Maiden name Maria Robertson

15. Birthplace Green Ridge, Md.

16. Informant Blanche Middleton

Address 233 Center St. Frostburg, Md.

17. Burial Date thereof 10 - 28 - 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Garrett Bair

Address Frostburg, Md.

19. 10 - 27 - 45 Miss Nancy N. Poe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1945 at 2 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1943 19 1943 to October 26 19 45

and that I last saw him alive on October 25 19 45

	DURATION
Immediate cause of death Uremia	3 wks
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hilda Laurie Walters, M.D. M. D. or other

Address Frostburg Date signed 10/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

09658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 430 Kean Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Alexander Munro

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 1 1864

8. AGE: Years	Months	Days	If less than one day
82	10	10	..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Retired Miner
11. Industry or business: Coal

FATHER
12. Name: William Munro
13. Birthplace: Scotland

MOTHER
14. Maiden name: Elizabeth Malcolm
15. Birthplace: Scotland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14 45 (month) (day) (year)
Cemetery or crematory: Oak Hill Cem.
Location: Lonaconing Md
18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Oct 13 1945 (Date rec'd by registrar) Winter K. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1945, at 11:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10. 5. 1945 to 10. 11. 1945 and that I last saw him alive on 10. 11. 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: ?
Due to: Hypertension — DURATION: ?
Due to: Arteriosclerosis — DURATION: ?
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D.
Address: Cumberland, Md. Date signed: 10-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-4)

CERTIFICATE OF DEATH

09659 ★ Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Latrobe St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Thomas Naughton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, 1875

8. AGE: Years 70 | Months 5 | Days 20 | If less than one day: hrs. min.

8. Birthplace: Barton- Allegany-Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Coal-Mine

FATHER
12. Name: Michael Naughton
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ann Dailey
15. Birthplace: Ireland

16. Informant: Michael Naughton
Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2 45. (month) (day) (year)
Cemetery or crematory: St. Gabriels Cemetery
Location: Barton, Md.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. 10-30 1945 Mrs Nancy N Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1945, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Oct 29 1945 and that I last saw him alive on Oct 29 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. M. Lowder M.D. M.D. or other
Address: Frostburg Md. Date signed: 10-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

09660

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred: Sylvan Retreat
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Patterson ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha L. Nefflen

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.): 11-18-1860

8. AGE: Years: 84 | Months: 10 | Days: 20 | If less than one day: hrs. mio.

9. Birthplace: Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Emil Nefflen
13. Birthplace: Wittenberg, Germany

MOTHER
14. Maiden name: Mary Eliza Louthan
15. Birthplace: Cumberland, Maryland

16. Informant: Mrs. Nefflen
Address: Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1945 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport, Md.

18. Funeral director: E. Clawson S. Brant
Address: Westernport, Md.

19. Oct 9 1945 (Date rec'd by registrar) Walter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1945, at 5:25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 26 1945 to Oct 8 1945 and that I last saw h[illegible] alive on Oct 6 1945

	DURATION
Immediate cause of death: Generalized Arteriosclerosis	
Due to: Infirmities of Age.	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 10-8-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09661

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred: 636 S. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 636 S. Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bridget Angela Roone

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): about 1860

8. AGE: Years	Months	Days	If less than one day
about 85	—		hrs. min.

9. Birthplace: Preston Co. W. Va.
(Town, county, and state)

10. Usual occupation: School Teacher.

11. Industry or business:

FATHER
12. Name: James Roone
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Nancy Le Kite
15. Birthplace: Ireland

16. Informant: Bernard Roone
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26, 45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland

18. Funeral director: Louis Stein Sons.

Address: Cumberland.

19. Oct. 25 19 45 Hunter & Fahey M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 19 45 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-20-1944 19 to 10-24-45 19

and that I last saw her alive on 10-23-45 19

Immediate cause of death: Myocarditis — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed: 10-26-45

Evidence for the change of age and additional DR 2 TOLSON date

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1376)

FILM No. G 98 OCT 19 1945

CERTIFICATE OF DEATH

★

Reg. Dist. No. 09662 4

1. PLACE OF DEATH:
County: ALLEGANEY
City or town: CUMBERLA D, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENN. County: SOMERSET
City or town: MEYERSDALE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 351 MEYERS AVE.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: OTTER, JOHN B. MR.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: RITTER, CORA V.

Mar. 2, 1870 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	1	..... hrs. ..... min.

9. Birthplace: GERMANY (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER — 12. Name: OTTER, JOSEPH

13. Birthplace: Germany

MOTHER — 14. Maiden name: JEORGER, MARY

15. Birthplace: Unknown

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1945 (month) (day) (year)

Cemetery or crematory: Wellersburg, Pa.

Location: Wellersburg, Penna.,

18. Funeral director: H. R. Konhaus

Address: Myersdale, Penna.,

19. Oct 4 1945 (Date rec'd by registrar) Winter L. Frantz M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-3- 1945, at 1 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-19- 1945, to 10-3- 1945 and that I last saw h.i.m. alive on 10-3-45 19..

Immediate cause of death: Benign hypertrophy prostate ? — DURATION

Due to:

Due to:

Other conditions: Myocardial degeneration ? Arteriosclerosis ? — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op. 10-1-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Howard L. Tolson M.D. M. D. or other

Address: Cumberland, Md. Date signed 10-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

DR. ZIMMERMAN

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09663

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 19½ BROWNING ST., CITY

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PIZARRO M. PONTON

3.(b) Social Security Number: 214-05-8388

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: KATHERINE GOOSBY

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 15, 1880

8. AGE: Years: 64 Months: 11 Days: 10 If less than one day: hrs. min.

9. Birthplace: VIRGINIA (Town, county, and state)

10. Usual occupation: LUMBER INSPECTOR

11. Industry or business: So. Cumb. Lumber Co.

FATHER — 12. Name: JOHN PONTON

FATHER — 13. Birthplace: VIRGINIA

MOTHER — 14. Maiden name: SALLY Howe

MOTHER — 15. Birthplace: VIRGINIA

18. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1945 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct. 27 19 45 (Date rec'd by registrar) Hunter R. Engt. M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT 25, 19 45, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 24, 19 45, to OCT. 25, 19 45 and that I last saw h... im alive on OCT 25, 19 45.

Immediate cause of death	DURATION
Coronary occlusion	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. Zimmerman M.D. M. D. or other

Address: Cumberland, Md. Date signed 10-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

09664

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland (If outside city or town limits, write RURAL and give nearest town) Rural
Street No.: Bowling Green, R.F.D. #5 (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth Ramhoff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Roland Ramhoff
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 24 - 1888

8. AGE: Years: 57 | Months: 9 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sand Patch Pa (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business:

FATHER
12. Name: Alfred Knepp
13. Birthplace: Sand Patch Pa

MOTHER
14. Maiden name: Pernda Geyer
15. Birthplace: Sand Patch Pa

16. Informant: Roland Ramhoff
Address: Cumberland R.F.D. 5

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. (month) 4 (day) 1945 (year)
Cemetery or crematory: White Oak Cem.
Location: Sand Patch, Penna.

16. Funeral director: J. J. Leuzt
Address: J. J. Frostburg Md.

19. Nov. 7, 1945 (Date rec'd by registrar) Wentz K. Hauk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1945, at 9.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1942 to October 31 1945 and that I last saw her alive on October 31 1945

	DURATION
Immediate cause of death: fractured skull	10 hours
Due to:	
Due to:	
Other conditions: diabetes epilepsy	several years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: fell from porch Date of: 10-31-45
Where did injury occur? Bowling Green (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: fell when cleaning window Injured at work?

23. SIGNATURE: L Wings MD M. D. or other
Address: Long Md Date signed: 10-31-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

69665

★ Reg. Diat. No. 6

1. PLACE OF DEATH

County: Allegany

City or town: Luke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Cromwell

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Luke (If outside city or town limits, write RURAL and give nearest town)

Street No. Cromwell (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry Alexander Rector

3. (b) Social Security Number: 216-09-7998

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1884

8. AGE: Years: 61 | Months: 3 | Days: 29 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Piedmont-Mineral- W. Va. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Plup & Paper Co.

FATHER — 12. Name: Charles Rector

FATHER — 13. Birthplace: Westernport, Md.

MOTHER — 14. Maiden name: Allie Lee

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Mrs. O.P. Maxwell

Address: Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 45 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal.

Address: Westernport, Md.

19. Nov. 1 1945 (Date rec'd by registrar) Gladys Baker MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30, 1945 at 5.30P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1945 to Oct 30 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION (Between onset and death)
Acute myocardial failure	
Due to Arteriosclerosis of Coronary arteries	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Norman Reese M.D. M. D. or other

Address: Westernport Md. Date signed 11-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS
C.L. Bmls

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

09666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 207 New Hampshire Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 New Hampshire Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gary Lynn Riggs

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 31, 1945

8. AGE:

Years	Months	Days	If less than one day
0	2	9	hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Md
(Town, county, and state)
10. Usual occupation Child
11. Industry or business

FATHER
12. Name Ralph E. Riggs
13. Birthplace Paris, Arkansas

MOTHER
14. Maiden name Maude E. Jones
15. Birthplace Meyersdale, Pa.

16. Informant Ralph E. Riggs
Address 207 New Hampshire Ave, Cumb.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11, 1945 (month) (day) (year)
Cemetery or crematory Mt. Herman Methodist Cem.
Location Near Cumberland, Md.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. Oct. 11, 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 20 1945
and that I last saw h alive on Sept 20 1945

	DURATION
Immediate cause of death	
Osteomyelitis	Sept 12
Due to	To
Cellulitis	death
Due to	since
	Sept
Other conditions Fracture Left Femur	20
Traumatic	1945

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. E. Owen M.D.
Address Cumberland, Md. M. D. or other
Date signed 10-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

09667

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1½ Hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war 2nd World War.

3.(a) FULL NAME EARL JAMES ROBERSON

3.(b) Social Security Number 214-05-6709

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Edna Martin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 2 1908

8. AGE: Years	Months	Days	If less than one day
36	10	14	..... hrs. ..... min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation Shell Driller Worker

11. Industry or business — auto —

FATHER 12. Name Edward Roberson

13. Birthplace Md.

MOTHER 14. Maiden name Susan Beeman

15. Birthplace Md.

16. Informant Mrs Edna Martin Roberson

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 1945 (month) (day) (year)

Cemetery or crematory Allegany Mem.

Location Frostburg Md.

18. Funeral director Louis Letzin Inc

Address Cumberland

19. Oct. 17 1945 (Date rec'd by registrar) Walter L. Trautz M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th, 1945, at 2.39 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... fo ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	one hour.
Due fo	
Due fo	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ----

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Pierce H. Boyer, M.D. M. D. or other

Address Cumberland, Maryland. Date signed 10-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

09668

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 a. Years
Hospital, institution, or street address where death occurred:
Sylvan Retreat
How long in hospital or institution? 2 Years 9 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 136. Independence St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Luther Robinson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Robinson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 8 1859

8. AGE: Years	Months	Days	If less than one day
86	8	10	..... hrs. ..... min.

9. Birthplace: Romney, Hampshire Co, West Virginia
(Town, county, and state)
10. Usual occupation: Night Watchman
11. Industry or business: Taylor Co
FATHER 12. Name: Unknown Robinson
13. Birthplace: Romney W. Va.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Romney, W. Va.
16. Informant: Vance Robinson
Address: 136. Independence St, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/21/45 (month) (day) (year)
Cemetery or crematory: Indian Mound Cemetery
Location: Romney, W. Va.
18. Funeral director: William H. Kight
Address: Cumberland, Md
19. Oct 20 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1945, at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 43 to Oct 18 1945
and that I last saw him alive on Oct. 16 1945
Immediate cause of death: General dilated Arteria Sclerosis
Due to: Infirmities of Age
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION

Major findings of operations: none
Date of op. none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 10-19-45

09663

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

CERTIFICATE OF DEATH

Reg. Diat. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution or street address (Where death occurred): 75 Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 75 Main
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Stephen Ross

3.(b) Social Security Number: 218-12-5748

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Della Poland Ross
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 22, 1887

8. AGE: Years	Months	Days	If less than one day
58		27	hrs. min.

9. Birthplace: Barton-Allegany-Md.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine

FATHER
12. Name: Lacy Ross
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Mandana Miller
15. Birthplace: (near) Westernport, Md.

16. Informant: Stanley Ross
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22 45 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Locaiion: Westernport, Md.
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Oct. 22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: October 19th., 19 45, at 2.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suicide by gunshot	killed instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 10-19-45
Where did injury occur? Westernport, (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: shot gun, 12 gauge Injured at work? no

23. SIGNATURE: Emma H. Doran, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 10-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

09679 ★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:
Miner's Hospital

How long in hospital or institution? 9 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Grahamtown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 54 Walnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. F. Schmeder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 29 - 1865

8. AGE: Years 80 | Months 1 | Days 22 | If less than one day ____ hrs. ____ min.

9. Birthplace Eckhart, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Miner, Coal

FATHER 12. Name Conradina Schmeder

13. Birthplace Germany

MOTHER 14. Maiden name Anna Pfuser

15. Birthplace Germany

16. Interment Mt. Evergreen Cemetery

Address 54 Walnut St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23-1945 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg, Md.

18. Funeral director Daniel J. Kaper

Address Frostburg, Md.

19. 10-23 1945 Mrs. Laney A. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1945 at 5 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 1945 to Oct 21 1945 and that I last saw him alive on Oct 20 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	Several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE W. M. McLane Jr. M.D.
M. D. or other

Address Frostburg Md. Date signed Oct 22 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

09671

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany County

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs.

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearsat town)

Street No. 509 Oldtown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine
Mrs. Clara Schultz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of Husband or wife Frank Jr. Schultz

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 30 1890

8. AGE:

Years	Months	Days	If less than one day
55	3	1	____ hrs. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joseph H. Rupp Jr.

13. Birthplace Deceased Md.

MOTHER 14. Maiden name Sophia Brinker

15. Birthplace Md.

16. Informant Mrs. Mary Louise Stein

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3 '45 (month) (day) (year)

Cemetery or crematory Ste Peter & Paul Cem

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Nov 2 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 19 45 at 4:38 A.M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from October 8 19 45 to October 31 19 45 and that I last saw h alive on October 30 19 45

Immediate cause of death	DURATION
(a) Acute Myocarditis	23 days
Due to (b)	
Due to (c)	
Other conditions Abscess left [illegible] Subcutaneous region	23 days

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE James V. Johnson M.D. M. D. or other

Address Cumberland Md. Date signed 11-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-0)

CERTIFICATE OF DEATH

09672

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

(M)

(I)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. COUNTY (ALLEGANY) HOME
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SEIBERT, WILLIAM MR.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) > > 1879

8. AGE: Years 66 | Months ? | Days > | If less than one day ... hrs. ... min.

9. Birthplace Garrett County, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Wm M Mathews

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/45 (month) (day) (year)

Cemetery or crematory Allegany County Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Sons

Address Cumberland, Md.

19. Oct. 9 1945 (Date rec'd by registrar) Walter R Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-1945 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-4-1945, to 10-8-1945 and that I last saw h.. alive on 10-8-1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis (Cerebral) ?	
Due to (b) Generalized Arteriosclerosis ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results Refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland, Md. Date signed 10-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-P)

CERTIFICATE OF DEATH

09673

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Shirley Jean Shaffer

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): February 28, 1942
8. AGE: Years: 3 Months: 7 Days: 19 If less than one day ..... hrs. ..... min.
9. Birthplace: Frostburg Md. (Town, county and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: John Shaffer
13. Birthplace: Wellersburg Pa.

MOTHER
14. Maiden name: Leona Winebrenner
15. Birthplace: Mt. Savage, Md.

18. Informant: Leona Shaffer
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19, 1945 (month) (day) (year)
Cemetery or ~~crematory~~: Mt. Savage Methodist
Location: Mt. Savage, Md.

18. Funeral director: Howard D. Leagler
Address: Hyndman, Pa.

19. 10/18/45 (Date rec'd by registrar) Veronica McDermet Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 19 45 at 8:45 A M

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from September 10 19 45 to Oct 17 19 45 and that I last saw h.. alive on October 17 19 45

	DURATION
Immediate cause of death: acute Rheumatic Fever	6 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Topper MD M. D. or other
Address: Hyndman Pa Date signed 10/17/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ward)

CERTIFICATE OF DEATH

09674

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, Institution, or street address where death occurred:

408 Decatur St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Decatur St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence A. Smallwood

3.(b) Social Security Number: 705-12-4632

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Smallwood

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 11, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	27	...hrs. ...min.

9. Birthplace: Nearsville, Loudon Co, Virginia (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Baltimore & Ohio Railroad

FATHER

12. Name: Franklin Smallwood

13. Birthplace: Bolivar, W. Va.

MOTHER

14. Maiden name: Madora Virts

15. Birthplace: Nearsville, Va.

16. Informant: Mrs. Edith Smallwood

Address: 408 Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 11, 1945 (Date rec'd by registrar) Winter R. Prantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1945, at 7-10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8, 1945, to Oct 8, 1945 and that I last saw h... alive on Oct 8, 1945

	DURATION
Immediate cause of death: Exhaustion Due to Forensic Granulocytosis	2 days
Due to: Cancer of Rectum	7 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Dunn M. D. or other

Address: Cumberland Md. Date signed: 10/9/45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

DR. REYNOLDS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09675

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HSOPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: WEST VIRGINIA County: Mineral

City or town: RIDGELEY

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PATRICIA ANN SMITH

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	CHILD

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1945

8. AGE: Years | Months: 4 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland. Md.

(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: JESSIE SMITH

13. Birthplace: WEST VIRGINIA

MOTHER — 14. Maiden name: ELVA MORELAND

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/45 (month) (day) (year)

Cemetery or crematory: Upper Tract Cemetery

Location: Upper Tract, West. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Oct. 18, 1945 (Date rec'd by registrar) Walter R. Kantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 17, 1945, at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 14/45, 19.., to Oct 17, 19.45

and that I last saw h... alive on Oct 17/45, 19..

Immediate cause of death	DURATION
Pneumonia (Bronchial)	1
Fatal exhaustion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Louis Reynolds M.D. M. D. or other

Address: Cumberland Md. Date signed: Oct 17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09676

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 2 YEARS & 4 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: PRESTON
City or town: TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MR. THOMAS C. SMITH

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: INDIA MOELL
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): SEPT. 24, 1863

8. AGE: Years	Months	Days	If less than one day
82	0	20	..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business

FATHER
12. Name: JOHN SMITH
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: Unknown
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 14 45 (month) (day) (year)
Cemetery or crematory: Terra Alta Cem
Location: Terra Alta, W Va

18. Funeral director: A. F. Callen
Address: Terra Alta, W Va.

19. Oct. 16 19 45 Winter K D
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 14 1945, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1943 to 10-14-1945 and that I last saw h.. alive on 10-13-1945

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 10-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09677

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital Frostburg

How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Salomon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Baby

8.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1945

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 40 min.

8. Birthplace: Frostburg - Allegany - Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: John Milton Salomon

13. Birthplace: Uniontown Pa.

MOTHER

14. Maiden name: Ola Marie Smith

15. Birthplace: Garrett Co, Md.

18. Informant: Mrs. John M. Salomon

Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-7-1945 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: Jacob Oster

Address: Frostburg, Md.

19. 10-6-45 (Date rec'd by registrar) Mrs. Bailey N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945, at 10:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1945, to 1945

and that I last saw h alive on 19

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. McLane Jr. M. D. or other

Address Frostburg Md Date signed 10-6-45

WITHIN CORPORATE LIMITS

09678

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Michael Spangler

3.(b) Social Security Number 705-03-6327

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Viola Spangler
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): February 14, 1903

8. AGE: Years	Months	Days	If less than one day
42	7	27	hrs. min.

9. Birthplace: Johnstown, Pa.
(Town, county, and state)
10. Usual occupation: Car Inspector B&ORR
11. Industry or business

FATHER
12. Name: William Spangler
13. Birthplace: Johnstown, Pa.

MOTHER
14. Maiden name: Sadie Smith
15. Birthplace: Johnstown, Pa.

16. Informant: Mrs. Elsie Spangler
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4 1945 (month) (day) (year)
Cemetery or crematory: Somerset Memorial Park
Location: Somerset, Pennsylvania

18. Funeral director: Harvey A Snyder
Address: Hyndman, Pa.

19. Oct 3, 1945 (Date rec'd by registrar) Wister R Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 1945, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Oct 1 1945 and that I last saw h[illegible] alive on Oct 1 1945

Immediate cause of death	DURATION
Diabetic Coma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T Bailey Hunter M.D. M. D. or other
Address: Cumberland Md Date signed: 10/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09679

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 810 MARYLAND AVENUE (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME MRS. ANNA F. STRIDE CUMBERLAND, MD.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife ROBERT STRIDE 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) MARCH 30, 1875

8. AGE: Years 70 | Months 6 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace VIRGINIA (town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name JOHN MILLS

13. Birthplace VIRGINIA - DECEASED

MOTHER 14. Maiden name LUCINDA Unknown

15. Birthplace VIRGINIA - DECEASED

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Nov 1 1945 (Burial, cremation, or removal. Which?) Date thereof Burial (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md

18. Funeral director A R COFFMAN

Address Hagerstown Md

19. Oct 29 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1945 at 4:10 P. M. OCTOBER 28 45 4:10

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/20/45 19.. to 10/28/45 and that I last saw h.. alive on Oct 28 1945

Immediate cause of death	DURATION
Pneumonia	7 days
Due to Chr. Myocarditis	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. M. Wilson M.D.

M. D. or other

Address Cumberland Md DR. WILSON Date signed 10-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

09680

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:
County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 yrs.
Hospital, institution, or street address where death occurred:
Bedford Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bedford Drive
(If roral, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Oliver Walter Summers. **3. (b) Social Security Number** 715-20-6045

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Amanda Dipford
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1889

8. AGE: Years	Months	Days	If less than one day
55	10	15	hrs. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual occupation Custodian
11. Industry or business Firemen Hall
MOTHER FATHER
12. Name John H. Summers
13. Birthplace W. Va
MOTHER
14. Maiden name Ellen Cretcalf
15. Birthplace W. Va.
16. Informant Mrs Amanda Summers
Address Cresaptown Md.
17. Burial Date thereof Oct 4 '45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland
18. Funeral director Louis Stein Sons
Address Cumberland
19. Oct 3 1945 M. H. Summers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945 at 12 00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1942 to October 2 1945
and that I last saw h.. alive on September 30 1945

Immediate cause of death	DURATION
apoplectic stroke	4 days
Due to arterial hypertension	3 years
Due to chronic nephritis	
Other conditions Cancer of the prostate	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L Klinge M.D.
M. D. or other
Address Lonaconing Date signed 10-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09681

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 yrs.
Hospital, Institution, or street address where death occurred: Bridge Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bridge Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Bell Pallen Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Irwin Thomas
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 18, 1897

8. AGE: Years 48 | Months 2 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Robert Patton
13. Birthplace: Ayershire, Scotland

MOTHER
14. Maiden name: Euphemia
15. Birthplace: Ayreshire, Scotland

16. Informant: D. Irwin Thomas
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: W. M. Eichhorn
Address: Lonaconing, Md.

19. Oct. 9 1945 Dr. E. Don Fyfe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8th 1945, at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....
and that I last saw her alive on Oct. 8th 1945

	DURATION
Immediate cause of death: Coronary Occlusion (cardiac death)	
Due to: Hypertension	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. E. Don Fyfe M. D. or other
Address: Lonaconing Date signed Oct. 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS DR. ENFIELD

09683

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-c)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 DAYS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: W.VA. County: MINERAL
City or town: KEYSER (If outside city or town limits, write RURAL and give nearest town)
Street No. 195 S. MAIN ST. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MRS LUCY MARIE TIMBROOK
3. (b) Social Security Number: 235-32-7065

4. Sex: FEMALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: MARRIED
6.(b) Name of husband or wife: ELMER J, TIMBROOK
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): JULY 12, 1900
8. AGE: Years 45 Months 2 Days 21 If less than one day ... hrs. ... min.
9. Birthplace: W.VA. (Town, county, and state)
10. Usual occupation: WAITRESS
11. Industry or business: Hamilton's Restaurant
FATHER 12. Name: DENTON DOMAN
13. Birthplace: W.VA.
MOTHER 14. Maiden name: ELIZA JEWELL
15. Birthplace: VA.
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1945 (month) (day) (year)
Cemetery or cremalory: Mt Zion Church Cem
Location: Near Augusta, W. Va
18. Funeral director: B. W. McKiKwood
Address: Keyser W. Va
19. Oct. 4, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 3, 1945 at 4:00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1945 to Oct 3 1945 and that I last saw her alive on Oct 2 1945

Immediate cause of death: Carcinoma of Thyroid | DURATION
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations: Large malignant thyroid [illegible] Date of op. Sept 23 [illegible]
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: A C Enfield M. D. or other
Address: Cumberland Date signed: 10/3/45

VS A15

WITHIN CORPORATE LIMITS

09682

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (71)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in ~~hospital~~ or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Finney

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sidney Schriver Finney

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
85	—	—	....hrs. ....min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Coal Miner - Retired

11. Industry or business: Maryland Coal Co.

FATHER — 12. Name: Daniel Finney

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Ellen Burl

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. John McCutcheon

Address: Moscow

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: Oct. 14 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Allegany Co. Md.

18. Funeral director: M. Richardson

Address: Lonaconing, Md.

19. Oct. 13 1945 (Date rec'd by registrar) Walter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12. 1945 at 7:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-16-1939 to 10-12-1945 and that I last saw him alive on 10-10-1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to: Infirmities of Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 10-12-45

WITHIN CORPORATE LIMITS

09684

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany.
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 83 yrs.
Hospital, institution, or street address where death occurred:
20-W 1st St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany.
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20-W. 1st St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LAURA Virginia TWIGG

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed.

6.(b) Name of husband or wife James J. Twigg
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 20 - 1862

8. AGE:

Years	Months	Days	If less than one day
83	5	24	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name John H. Brant.
13. Birthplace Cumberland Md.

MOTHER
14. Maiden name Mary E. Green
15. Birthplace Cumberland, Md.

16. Informant Vincent D. Twigg
Address Keyser W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16 1945 (month) (day) (year)
Cemetery or crematory Greenmount Cem.
Location Cumberland, Md.

18. Funeral director Lavin Steele Inc.
Address Cumberland, Md.

19. Oct. 15, 45 (Date rec'd by registrar) Winter R. Brant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945 at 12:30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 - 45 19 to Oct 14 45 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Chronic Valvular Heart disease.	5 yrs.
Due to age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M E B Owens M. D. or other
Address 133 Va Ave Date signed 10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09685

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City: Rural Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 2 Williams Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Teresa Louise Twigg

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~F~~ F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8, 1945

8. AGE:

Years	Months	Days	If less than one day
0	2	23	..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Joseph R. Twigg
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Teresa A. Davis
15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Teresa A. Twigg
Address: Route 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland Md

18. Funeral director: John J. Hoffer

Address: Cumberland, Md.

19. Nov. 1, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1945 19..... at about 3A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Accidental Suffocation	
Due to: Head becoming covered with bed-clothing	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 10-31-45
Where did injury occur? R.D. 2 Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: suffocation Injured at work? no

23. SIGNATURE: Pierce H. Bolan M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 10-31-45

Deputy Medical Examiner - Acting by OB.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09686

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, Institution, or street address where death occurred: 521. Cumberland St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 521. Cumberland St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jesse E. Utt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Utt

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): December 6 1868

8. AGE: Years	Months	Days	If less than one day
76	10	11	....hrs. ....min.

9. Birthplace: Greenwood Township, Columbia Co, Pa (Town, county, and state)

10. Usual occupation: Real Estate

11. Industry or business: Selling Houses

FATHER

12. Name: David Utt

13. Birthplace: Milton, Pa.

MOTHER

14. Maiden name: Margaret Follmer

15. Birthplace: Milton, Pa.

16. Informant: Mrs. Mary Utt

Address: 521. Cumberland St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/20/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 19 1945 (Date rec'd by registrar) Walter A. Duffy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17th., 1945, at 3.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Cerebral Hemorrhage (Apoplectic Stroke)	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Bowen M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 10-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-d)

CERTIFICATE OF DEATH

09687

★ Reg. Dist. No. 9

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: R.F.D. 1 Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Melvin Francis Wade

3.(b) Social Security Number: 214-07-0567

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Nellie Wade
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): August 24 1889

8. AGE: Years	Months	Days	If less than one day
56	1	8	...hrs. ...min.

9. Birthplace: Frostburg Allegany Cty. Md. (Town, county, and state)
10. Usual occupation: rubber worker
11. Industry or business: Kelly-Springfield Tire Co.
FATHER — 12. Name: Enoch Wade
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Mary Wienault
MOTHER — 15. Birthplace: Maryland
16. Informant: Mrs. Nellie Wade
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 6-1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Obrist
Address: Frostburg Md.
19. 10-4 (Date rec'd by registrar) 45 Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1945 at 11 00 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 1945 to Oct 3 1945 and that I last saw him alive on Sept 2nd 1945

Immediate cause of death	DURATION
Brain Tumor	3 mo
Due to: Not known, whether benign or malignant. Susp.	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Brain Tumor. Date of op. ? 7
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W O M Lane Jr MD M. D. or other
Address: Frostburg Md Date signed: Oct 3 1945

Elizabeth Brown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09688

Reg. Diat. No. 6-

1. PLACE OF DEATH:
County: Allegany
City or town: Rural near Rawlings,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, Institution, or street address where death occurred:
Residence near Rawlings
How long in hospital or institution? R.D. 3 Keyser, W. Va.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural near Rawlings
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural near Rawlings, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Horace Resley Warnick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ellen Jane (Custer)
6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): Nov. 26, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	27	...hrs. ...min.

9. Birthplace: New Germany, Maryland
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Ashford Warnick
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Magdalen (Michael)
MOTHER 15. Birthplace: Maryland
18. Informant: Ellis Warnick
Address: Keyser, R.D. #3
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1945 (month) (day) (year)
Cemetery or crematory: Hill Crest
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Greene St. Cumberland, Maryland
19. 10/26/45 (Date rec'd by registrar) M. V. Yauney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23, 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/21/45 to ... 19...
and that I last saw him alive on 10/21/45

Immediate cause of death	DURATION
congestive heart failure	months
Due to: 4 year diabetes	
Due to:	
Other conditions: Old age	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Brown M.D.
M. D. or other
Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 27 1945

WITHIN CORPORATE LIMITS

09689

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Years

Hospital, Institution, or street address where death occurred: 1017. Virginia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1017. Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Daisy Whisner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William A. Whisner

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): July 23 1883

8. AGE: Years	Months	Days	If less than one day
62	3	13	....hrs. ....min.

9. Birthplace: Windom, Mineral Co, West Virginia (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER — 12. Name: Madison Blackburn

FATHER — 13. Birthplace: Romney W. Va.

MOTHER — 14. Maiden name: Caroline Brown

MOTHER — 15. Birthplace: Romney, W. Va.

16. Informant: William A. Whisner

Address: 1017. Virginia Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/8/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 8 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1945, at 12-50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to Oct 6. 1945

and that I last saw h alive on Oct 5 1945

Immediate cause of death	DURATION about
Carcinoma	34 yrs
Due to: Left Breast.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: 133 Va ave Date signed: 10/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

09690

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: JENNINGS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. LOMAN WILT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 1, 1903

8. AGE: Years	Months	Days	If less than one day
42	8	23	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: FARMER
11. Industry or business

FATHER
12. Name: CHARLES WILT
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: MARY FAZENBAKER
15. Birthplace: MARYLAND

18. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27 1945 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore, Md.
18. Funeral director: Wm. Whitesberg
Address: Grantsville, Md.

19. Oct. 27 1945 (Date rec'd by registrar) Hunter R. Dent, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT 24, 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 18, 1945 to OCT. 24, 1945 and that I last saw him alive on OCT. 24, 1945

	DURATION
Immediate cause of death: Gunshot wound abdomen.	6 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Perforations x 2 intestine Date of op. 10-18-45

Autopsy results: Hemorrhage & necrosis of intestine

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-18-45
Where did injury occur? Garrett, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where)? In woods.
Means of injury: Gunshot Injured at work?

23. SIGNATURE: D. E. Boone M.D.
M. D. or other
Address: Medical Bldg Date signed 10-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09691

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs

Hospital, Institution, or street address where death occurred:

216 Fredericks St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Fredericks St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mary Minroe Winters

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife Charles Winters

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 17, 1888

8. AGE:

Years	Months	Days	If less than one day
57	4	0	....hrs. ....min.

9. Birthplace Lonaconing Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name Arch Brown

13. Birthplace Lonaconing Md.

MOTHER 14. Maiden name Mary A. Brown

15. Birthplace Lonaconing Md.

16. Informant Charles Winters

Address 216 Fredericks St - Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 1945 (month) (day) (year)

Cemetery or crematory Vale Summit Cemetery

Location Vale Summit Md.

18. Funeral director John J. Haley

Address Cumberland, Md.

19. Oct. 19 1945 Winter R. Trautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1945, to Oct 17 1945

and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Cerebral apoplexy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. H. Walker M.D.
M. D. or other

Address 49 Greene St Date signed 10-18-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15